This is not to say that there are not times when good medical practice indicates the need for amphetamines. My objection is to the use of them in such a way as to obscure a psychological problem.

Just as fever is an indication that something is wrong with the functioning of the physiological mechanism of the body, so are anxiety, depression, fatigue or prolonged insomnia signals of increased "fever" in the psychological mechanism. Just as fever ought not be alleviated without effort to determine the cause, so these signals must be examined and evaluated before chemotherapy to reduce or eliminate them are prescribed.

Tension, frustration and anxiety have existed in all ages and in all cultures, and probably will continue to plague us so long as man strives. The goal of chemotherapy and psychotherapy cannot then be to eliminate these feelings and reactions merely for the sake of achieving tranquillity, unless we are prepared to produce human vegetables.

The goal of therapy, whether chemical or psychological, should not be merely to effect a state of blissfulness. The goal, rather, should be to use all the therapeutic tools at hand to enable men and women to participate actively in their environment and to cope with the realities of that environment. A sense of well-being cannot for long be achieved by obscuring the presence of conflicts and dangers, but only by recognizing and dealing with them. The patient must learn how to use his energies toward handling conflicts, removing them when possible, or changing those areas which create threatening situations for him. And through it all, he must learn how to cope with his feelings as he is reacting to his environment.

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Psychiatric Emergencies

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HEIGHTENED INTEREST in the early recognition and prompt treatment of psychiatric emergencies in medical practice has come in part from the changing pattern of medical illnesses dealt with by general physicians, who now less often treat acute infectious inflammatory diseases and more often of the intermittent disabling illnesses consisting mostly of psychosomatic disorders, emotional states and geriatric problems. These illnesses are most frequently seen initially by physicians in general practice, who are in a most strategic position to serve as a first line of defense against acute psychiatric disorders.

The Suicidal Patient

Suicide, which must always be anticipated in depressed or delirious persons and in acutely psychotic patients, is a true psychiatric emergency. To recognize these psychic disorders is to anticipate attempted self-destruction. As many clues as are available must be sought and utilized to differentiate the threat of suicide as a dramatic manipulatory device from the likelihood of its occurrence. A depressed patient shows a decrease in psychic and motor activity, a feeling of hopeless despair and a withdrawal of interest. He talks of suicide, speaks of remorse and has feelings that his family is better off without him. He is unable to plan for the future, is indecisive and feels lost. He is self-depreciatory and very early complains of loss of appetite. He sleeps poorly, awakens early in the morning and is unable to return to sleep. This accounts for many suicidal attempts during the early morning hours. The disturbance in mood is frequently preceded by many vague physical complaints usually indicative of a general slowing up. The element of guilt, self-depreciation and feelings of hopelessness separate this group from the neurotic states with concurrent depressive anxious feelings in which the gesture of suicide is used as a controlling device. By this means such people gain some point in their interpersonal relationships—either affection and solicitude or, perhaps, the release of resentment held towards others. Such patients need not be put in a hospital since, having gained their point through threat or gesture, they are for the time being satisfied.

A depressed, suicidal patient, however, should be put in a hospital and there every precaution must be taken against the possibility of self-destruction. Such a patient needs to be on the ground floor or first floor of a closed, screened hospital unit or with special nurses if adequate closed facilities are unavailable. Special nurses are helpful, since such personnel act as parental substitutes, giving adequate attention and solicitude as compensation for injured self-depreciatory feelings. Direct questioning need not be avoided. Questions should be frankly concerned with the patient's spirits, the presence of thoughts of death, his wish to live or die, his ability to face and plan for the future. The physician frequently is reluctant to ask such direct questions lest he offend the sensitivity of the patient; but more frequently such reservations may be based on his own fears and the misconception that direct questions may implant ideas of suicide.

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It is the moderately depressed patient who is most likely to try to kill himself, rather than the profoundly depressed person in the depth of despair whose initiative is at such low ebb that none of his faculties can be mobilized for any action.

Acute Intoxications

The acute intoxications including alcoholic, bromide and barbiturate overdosage represent true psychiatric emergencies with a real threat to the life of the patient. Such intoxications may exist alone or in combination with any injury or illness in the course of which physical resistance is lowered. In these conditions there is primarily a loss of coordination, but excitement and some combativeness. The symptoms of barbiturate overdosage are clouding of consciousness, ataxia, nystagmus and slurred speech. The treatment of barbiturate intoxication includes immediate gastric lavage, maintenance of adequate respiratory exchange, suction for removal of pooled secretions in the throat, antibiotics for the prevention of pulmonary complications and administration of adequate fluids and mild stimulants. Sudden complete withdrawal of barbiturates may cause seizures. Bromide intoxication results in agitated states with increased salivation and bizarre visual hallucinations. Treatment includes the "forcing" of fluids, giving enemas and the administration of sodium chloride.

Delirium, a psychiatric emergency, is characterized by clouding of consciousness, gross distortion in perception, disorientation and at times hallucinations. Such reactions sometimes occur also in physical illness, as in cardiac decompensation, pulmonary edema and postsurgical states as well as in eclampsia and in exhausting infectious disease. The symptoms of tremor, sweating and flushing, together with disorientation and cloudy mental state, bespeak the diagnosis. Such patients are best treated in a quiet, nonstimulating, restful environment in a dimly lighted room with special nursing care. The presence of a few personal possessions such as photographs helps to keep the patient in close contact with reality. Close personal attention, adequate intake of fluids and maintenance of nutrition with small doses of insulin are recommended. Giving Sparine® or reserpine intravenously is helpful. Restraints are not indicated and should be avoided whenever possible. Patients in delirium are frightened and must be protected against their own fears and prevented from panic reaction which may result in suicidal attempts to escape their projected fears.

Organic Mental Syndromes

With the conquest of acute infectious diseases, the life span has increased, with the result that physicians now are dealing more and more with older patients. General physicians nowadays are confronted by many problems associated with aging, which are frequently diagnosed as organic mental syndromes. The psychic implications of senescence are frequently a psychiatric emergency, especially if there is a reaction of excitement with disorientation and confusion. The patient may feel lost, may be frightened and perplexed and react to his situation with much antagonism. Excitement and agitation in senescent patients must be treated with quiet assurance and administration of specific tranquilizers. Keeping the patient in the familiar surroundings of home, limiting the number of visitors, giving special solicitous nursing care (best provided by a favored member of the family) and continued care by the physician are advisable in light of the large psychological component in the genesis of senile deterioration. The state of the patient is not entirely owing to the vascular changes in the brain, but is due in part to changes in his environment or in his attitude toward himself. The older person begins to feel himself a burden with limitations in his physical and mental capacity. He loses loved ones and friends through death, and the world is new and strange to him. He senses the hostility in others toward him for being in the way and he reacts with resentment. Guilt over resentment leads to self-depreciation and depression. Loneliness leads to hypochondriacal preoccupation. The patient becomes greatly concerned with bodily symptoms and excretory functions, since his body now provides the main source of interest. He is, as it were, withdrawing to his own body for solace. Fearing the loss of identity in terms of loss of usefulness and sexual interest, he no longer tries to adjust to new conditions. He withdraws, becomes ill, shows increasing irritation, combativeness and argumentation. He frequently is depressed and has paranoid ideas in which he projects much of his feelings of insecurity and hostility on others.

The goal of treatment best attained by the physician is to help the patient to accept himself. Interest and understanding on the part of the physician is essential in order that the aged person has someone to talk to, someone he feels is sympathetic and interested in him personally. The patient should be kept in his own home, his life orderly and routine and free of nagging relatives. He should be attended by a family member. A nightlight should be kept burning to avoid fright, and every new procedure should be explained beforehand.

Many of these elderly patients will recover from the acute psychiatric emergency even though there may be damage to the brain.

Acute Functional Syndrome

The psychiatric emergency of acute functional psychic disorder results from a fear of loss of control of thought and behavior. This fear leads to a desocialization, withdrawal, and alienation from others. The anxiety which cannot be tolerated because of the fear of psychic disintegration leads to uncontrolled excitement or extreme inhibition. In the paranoid schizophrenic and manic-depressive reactions, the patient may have negative, hostile destructive feelings toward persons on whom he is dependent. The conflict may erupt in violent, uncontrolled, aggressive behavior, often preceded by physical complaints of vague, often bizarre nature. Paranoid reactions are often introduced by intense hypochondriacal complaints for which the patient will accept no reassurance of explanation. Expressions of hatred and of obviously false beliefs are diagnostic. When the hatred becomes so intense that the patient can no longer contain himself, he will project his feelings of hostility upon others, feel in danger of attack and therefore attack others or himself. The warning signs are increasing tension, increasing agitation, resentment and demands from others. Putting the patient in a hospital and the administration of promazine is recommended.

Paranoid reactions in postsurgical patients, which occur frequently, are best treated with frank discussion of misinterpretations and misidentifications, and with assurance and orientation to reality.

Anxiety States

The acute anxiety attack may be a psychiatric emergency, especially when it assumes panic proportions. There are multiple somatic symptoms, and autonomic imbalance which may be likened to the racing of an automobile engine while the car is stationary. Such anxiety is usually related to aggressive thoughts and fantasies which are very frightening to the patient. These states are frequently precipitated by visual scenes of violence on television or motion picture programs. The patient feels his heart palpitating, has difficulty in breathing, is sweating or feels chilly, and there is a great fear of impending death. Sleep produces disturbing dreams in which he relives threats of his childhood. He is helpless, is rooted to the ground, is falling over a precipice. He wants to call for help but is unable to speak.

Such conditions can engender reactive anxiety in the physician who is treating the patient. It is essential that the physician, having satisfied himself as to the absence of organic condition through adequate physical examination, remain calm and unhurried and be reassuring to the patient. Any semblance of aggression in the treatment of a violent, agitated patient must be assiduously avoided, for the patient is acutely fearful of aggression. Physical force, restraints, hustling or mishandling of the patient is contraindicated, but a firm, kindly and authoritative touch will be of immeasurable help.

Postpartum Psychic Reactions

Postpartum anxiety and depressive reactions occur in situations in which maternity mobilizes in the patient earlier childhood conflicts—usually of sibling rivalry or of mixed feelings toward her parents. Here reassurance, adequate sedation, the use of a motherly nurse and temporary relief of the maternal responsibility will often lessen the intense agitation the patient feels. The closer the reaction to the time of birth, the greater the possibility of psychotic reaction. The patient in whom feelings of inadequacy, tension and fears of hurting her child develop after she leaves the hospital, is probably the neurotic anxious patient. She can be effectively treated with appropriate sedation and psychotherapy.

DISCUSSION

The acute psychiatric conditions in medical practice consist primarily of depression with possibility of suicide, acute intoxication, delirium and other organic and functional mental syndromes. Psychologically and clinically these are manifestations of the fear of disorganization as seen in the organic mental syndromes, desocialization as seen in the psychoses, and deterioration as seen in the aged. The diagnosis is not often obscure but effective management may be difficult, since treatment is also based on the physician's own attitude toward psychiatric disorders.

Disorders of thought and behavior are defensive mechanisms against overwhelming fear of psychic dissolution, just as fever, pain, leukocytosis and tenderness are attempts of the body to localize infection and prevent spread and bodily destruction. The symptoms of psychic disorder are attempt at restitution and to ward off the inroads of the disorder. Psychiatric patients are fearful of their own internal disruptive and aggressive drives. The fear of loss of control leads to disorganized behavior. The physician must lend stability through his own calmness and reassuring attitude. He must not be fearful nor aggressive. Rarely will violence be directed toward the physician by the patient. As between the patient and the physician, the former is always more fearful and it is better that the patient remain the anxious one. In such situations the treatment of the acute psychiatric disorder, although exigent in nature, need not be a harrowing experience for the physician.

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